

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10372

County WicomicoVillage or City Salisbury Md. (No. Camden St. Ward 13)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Hugh Henry Hooper Adams

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widower
(Write the word)

6 DATE OF BIRTH Aug. 1882
(Month) (Day) (Year)7 AGE 62 yrs. 1 mos. ds. OR 1 day, hrs. min. ?
If LESS than 1 day, hrs. min. ?

8 OCCUPATION Home Painter
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

PARENTS
10 NAME OF FATHER John Adams
11 BIRTHPLACE OF FATHER (State or country) Maryland
12 MAIDEN NAME OF MOTHER Elizabeth Williams
13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs. Hannah M. Townsend(Address) Salisbury Md.15 Filed Oct 16, 1914 W. B. Sumner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 14, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 14, 1914, to Oct 14, 1914that I last saw him alive on Oct 14, 1914and that death occurred on the date stated above, at 3 30 m.

The CAUSE OF DEATH* was as follows:

Angina PectorisFrom Injuries
(Duration) yrs. mos. ds.Contributory
Secondary(Duration) yrs. mos. ds.(Signed) W. B. Sumner, M. D.Oct 16, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

19 PLACE OF BURIAL OR REMOVAL

Parsons Cem. SalisburyDATE OF BURIAL Oct. 16th 3:30 p.m., 1914

20 UNDERTAKER

Geo. C. Hill

ADDRESS

Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

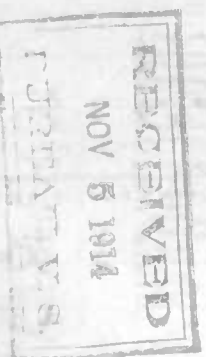
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. ~~For report~~ more symptoms or terminal conditions, such as *As-thenia*, "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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185-2
29
1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wicomico</u>		10373 (117)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Wetipgum</u> (No.)		St.;		Ward)	
2 FULL NAME <u>Kate D. Bedsworth</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>July 29</u> , 1886 (Month) (Day) (Year)					
7 AGE <u>28</u> yrs. <u>2</u> mos. <u>20</u> ds. If LESS than 1 day, hrs. OR min. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>housekeeper</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS	10 NAME OF FATHER <u>Isaac Mills</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>				
	12 MAIDEN NAME OF MOTHER <u>Charlotte Jenkins</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>E. Stanley Bedsworth</u> (Address) <u>Wetipgum Md</u>					
15 Filed <u>Oct. 9</u> , 1914 <u>L. T. Haller</u> <u>Local</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 9</u> , 1914 (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 6th</u> , 1914, to <u>Oct 8th</u> , 1914, that I last saw him alive on <u>Oct 8th</u> , 1914, and that death occurred on the date stated above, at <u>2 A</u> m. The CAUSE OF DEATH* was as follows: <u>Pneumonia</u>					
(Duration) yrs. mos. ds.					
Contributory Secondary (Duration) yrs. mos. ds.					
(Signed) <u>R E Caswell</u> , M. D. <u>Oct 9th</u> , 1914 (Address) <u>Baltimore Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, if not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Quantico M.E. Cemetery</u>				DATE OF BURIAL <u>Oct 10</u> , 1914	
20 UNDERTAKER <u>C. S. Messick</u>				ADDRESS <u>Baltimore Md</u>	

1

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 10374

County WiconicoVillage or City Helmar (No. _____)

St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 336

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Albert James Booth

PERSONAL AND STATISTICAL PARTICULARS

3 SEX male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) single

6 DATE OF BIRTH 11 22 1933
(Month) (Day) (Year)

7 AGE 11 yrs. 11 mos. 11 ds. 11 LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work _____
(b) General nature of industry, business, or establishment in which employed (or employer) _____

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Albert James Booth

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Lavinia Smith

13 BIRTHPLACE OF MOTHER (State or country) Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Albert J. Booth(Address) Helmar, Dela

15 Filed Oct 22 1914 W & L W & L

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH 12 29 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 1, 1914, to Oct 21, 1914, that I last saw him alive on Oct 19, 1914,

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Massacrum

Contributory _____
Secondary _____

(Signed) M. W. Ellis, M. D.
Oct 22, 1914 (Address) Helmar, Dela

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death? _____

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Helmar DATE OF BURIAL Oct 22, 1914

20 UNDERTAKER M. W. Ellis ADDRESS Helmar, Dela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

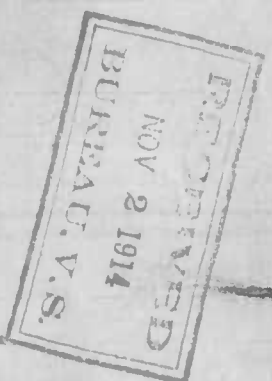
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 10375
 County Wicomico (64)
 Village or City Salisbury (No. _____, St. 7 Ward) Trappe
 2 FULL NAME James Mariah Bounds

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 334

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
 (Write the word)
 6 DATE OF BIRTH Jan. 1, 1889
 (Month) (Day) (Year)
 7 AGE 75 yrs. 10 mos. 10 ds. OR 1 day, 10 hrs. 10 min. ?
 8 OCCUPATION
 (a) Trade, profession, or particular kind of work None
 (b) General nature of industry, business, or establishment in which employed (or employer) Housewife
 9 BIRTHPLACE (State or country) Maryland

PARENTS

10 NAME OF FATHER James E. White
 11 BIRTHPLACE OF FATHER (State or country) Maryland
 12 MAIDEN NAME OF MOTHER I don't know
 13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE
 (Informant) Peter Bounds
 (Address) Salisbury, Md.

15 Filed Oct 31, 1914. J. Rodney Jones
 REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 30, 1914
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 20, 1914, to Oct 30, 1914

that I last saw her alive on Oct 30, 1914

and that death occurred on the date stated above, at 2:30 P.m.

The CAUSE OF DEATH* was as follows:

Hemiplegia following Apoplexy

(Duration) 10 yrs. 10 mos. 10 ds.
 Contributory Advanced age
 Secondary

(Duration) 10 yrs. 10 mos. 10 ds.
 (Signed) Jos. R. Needham, M. D.
Oct 30, 1914 (Address) Fruitland, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Silham DATE OF BURIAL Oct 31, 1914
2 P.m.

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Maras- mus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL *septicæmia*," "PUERPERAL *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, STREPTAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10376

County

Aniconico

Village or City

Near Salisbury

(No.)

St.;

Ward)

Registration Dist. No. 334

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Jane Cathell

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

female

4 COLOR OR RACE

a

5 SINGLE,

MARRIED,

WIDOWED,

OR DIVORCED

(Write the word)

married

DATE OF BIRTH

Apr.

(Month)

(Day)

1886

7 AGE

79

yrs.

mos.

ds.

If LESS than
1 day, hrs.
OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

not any

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Daniel Menick

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Mary Menick

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elizabeth Anderson

(Address)

near Salisbury Md.

15

Filed

Nov. 21, 1914

J. Rodney Jones

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct.

31

1914

(Month)

(Day)

(Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 27, 1914, to Oct. 31, 1914.

that I last saw him alive on Oct. 30, 1914.

and that death occurred on the date stated above, at 9 P. m.

The CAUSE OF DEATH was as follows:

Hemiplegia, caused by cerebral hemorrhage

(Duration) yrs. mos. ds.

Contributory
Secondary

Rheumatism

A number of years

(Duration) yrs. mos. ds.

(Signed)

J. W. Roberts

M. D.

Nov. 2, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death 79 yrs. mos. ds. In the State 79 yrs. mos. ds.

Where was disease contracted,
If not at place of death?

Former or usual residence Salisbury Md.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Houston Cemetery

Nov 2, 1914

20 UNDERTAKER

ADDRESS

H. Stewart Salisbury Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification, as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cause" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Prosy," "Exhaustion," "Heart failure," "Hæmorrhage," "Ipantiod," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH

10377

139

STATE OF MARYLAND
CERTIFICATE OF DEATH

County

Mcomico

Registration Dist. No. 333

Village or City

Salisbury

(No.)

Camden St

St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

John P. Chatham

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)

6 DATE OF BIRTH

July 2, 1872
(Month) (Day) (Year)

7 AGE

42 yrs. 3 mos. 1 ds. OR min. ?
If LESS than 1 day, hrs.

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

Fireman in mill.

9 BIRTHPLACE (State or country)

Worcester Co

PARENTS

10 NAME OF FATHER

Josephus Chatham

11 BIRTHPLACE OF FATHER (State or country)

Worcester Co

12 MAIDEN NAME OF MOTHER

Lucilla A. Micey

13 BIRTHPLACE OF MOTHER (State or country)

Mcomico

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Francis M. Chatham

(Address)

Salisbury Md.

15

Oct 5, 1914

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 3, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

I saw deceased after death Oct 3, 1914.

that I last saw him alive on about 1 week ago.

and that death occurred on the date stated above, at 9:15 a.m.

The CAUSE OF DEATH* was as follows:

Pistol wound through right temple (Suicide)

Contributory Secondary

(Duration) Immediate

Secretion of brain & hemorrhage

(Duration) Immediate

(Signed) M. D.

Oct 3, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Parsons cemetery

Oct 5, 1914

20 UNDERTAKER

ADDRESS

George C. Hill Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

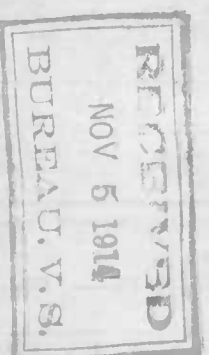
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH <i>Wisconsin</i>		10378		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <i>Hebron</i>		(No. <i>92</i>)		Registration Dist. No. <i>338</i>	
Village or City <i>Hebron</i>		(No. <i>92</i>)		St.; Ward	
2 FULL NAME <i>Agnes Darby</i>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <i>Female</i>	4 COLOR OR RACE <i>White</i>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <i>—</i>			
6 DATE OF BIRTH <i>Aug 27, 1914</i> (Month) (Day) (Year)					
7 AGE <i>1</i> yrs. <i>28</i> mos. <i>28</i> ds. OR <i>LESS than 1 day, hrs. min. ?</i>					
8 OCCUPATION (a) Trade, profession, or particular kind of work <i>—</i> (b) General nature of industry, business, or establishment in which employed (or employer) <i>—</i>					
9 BIRTHPLACE (State or country) <i>Hebron</i>					
PARENTS	10 NAME OF FATHER <i>George Darby</i>				
	11 BIRTHPLACE OF FATHER (State or country) <i>Md.</i>				
	12 MAIDEN NAME OF MOTHER <i>Minnie A. Jenkins</i>				
	13 BIRTHPLACE OF MOTHER (State or country) <i>Delaware</i>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <i>George Darby</i> (Address) <i>Hebron Md.</i>					
15 Filed <i>191</i>					
REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <i>Oct 25, 1914</i> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <i>191</i> to <i>191</i> , that I last saw him <i>alive on</i> , <i>191</i> , and that death occurred on the date stated above, at <i>—</i> m. The CAUSE OF DEATH* was as follows: <i>Pneumonia</i> (Duration) <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds.					
Contributory Secondary (Duration) <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds.					
(Signed) <i>H. C. Lamm</i> , M. D. <i>Oct 26, 1914</i> (Address) <i>Hebron Md.</i>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. In the State <i>—</i> yrs. <i>—</i> mos. <i>—</i> ds. Where was disease contracted, If not at place of death? Former or usual residence <i>—</i>					
19 PLACE OF BURIAL OR REMOVAL <i>Martela Spgs.</i>				DATE OF BURIAL <i>Oct 26, 1914</i>	
20 UNDERTAKER <i>H. A. Gravenor & Co</i>				ADDRESS <i>Sharptown Md</i>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH.

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not faintly employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Tremor," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 10379		STATE OF MARYLAND CERTIFICATE OF DEATH	
County <u>Wicomico</u>		Registration Dist. No. <u>333</u>	
Village or City <u>Pine Bluff Langdon</u> <u>near Salisbury</u> (No. <u>Condemned</u> St. <u>13</u> Ward)		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Mr. A. Edelen</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Male</u>	4 COLOR OR RACE <u>African</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)	
6 DATE OF BIRTH <u>Don't know</u> (Month) (Day) (Year)			
7 AGE <u>30</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds. OR <u>1</u> day, <u>1</u> hrs. <u>1</u> min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer or</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u>Labour on farm</u>			
9 BIRTHPLACE (State or country) <u>Don't know</u>			
PARENTS	10 NAME OF FATHER <u>Don't know</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Don't know</u>		
	12 MAIDEN NAME OF MOTHER <u>Don't know</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Don't know</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Geo. W. Todd</u> (Address) <u>Salisbury Md</u>			
15 FILED <u>Oct 27</u> , 191 <u>4</u> <u>W. H. M. M. M.</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Oct. 26</u> , 191 <u>4</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept 26</u> , 191 <u>4</u> , to <u>Oct 26</u> , 191 <u>4</u> , that I last saw him alive on <u>Oct 26</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>11 P.</u> m, The CAUSE OF DEATH* was as follows:			
<u>Pneumonia Pulmonalis or</u> <u>Exhaustion</u> (Duration) <u>Don't know</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds.			
Contributory Secondary <u>Tuberculosis</u> (Duration) <u>Don't know</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds.			
(Signed) <u>Geo. W. Todd</u> , M. D. <u>Oct 27</u> , 191 <u>4</u> (Address) <u>Salisbury Md</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>Don't know</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds. In the State <u>Don't know</u> yrs. <u>Don't know</u> mos. <u>Don't know</u> ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Waldorf Charles Co</u>		DATE OF BURIAL <u>Oct 29</u> , 191 <u>4</u>	
20 UNDERTAKER <u>Ed Stewart</u>		ADDRESS <u>Salisbury Md</u>	

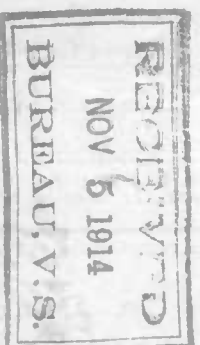
REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Scutle," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH **10380**
 County **Neonico** (28)
 Village or City **Neon Sharpstown** (No.) St. Ward
 2 FULL NAME **Paul R. Giles**
 Registration Dist. No. **338-**
 [If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE Col	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
6 DATE OF BIRTH Jan 3, 1873 (Month) (Day) (Year)		
7 AGE 41 yrs. 9 mos. 28 ds.		If LESS than 1 day, hrs. OR min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work Cook. (b) General nature of industry, business, or establishment in which employed (or employer) On Steam Vessel		
9 BIRTHPLACE (State or country) New Jersey		
PARENTS	10 NAME OF FATHER Unknown	
	11 BIRTHPLACE OF FATHER (State or country) " "	
	12 MAIDEN NAME OF MOTHER Mariah Johnson	
	13 BIRTHPLACE OF MOTHER (State or country) Unknown	

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) **Byard A. Lumtoui**
 (Address) **Sharpstown, Md.**

15 Filed **11/1**, 1914 **Wm. A. ...**
 REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH **Oct 31, 1914**
 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from **Oct. 1st**, 1914, to **Oct 31**, 1914, that I last saw him alive on **Oct 31**, 1914, and that death occurred on the date stated above, at **Oct 31** m.
 The CAUSE OF DEATH* was as follows:
Tuberculosis of the lung

(Duration) yrs. **6** mos. ds.
 Contributory **Chronic Nephritis**
 Secondary **Diffuse Nephritis**
 (Duration) yrs. mos. ds.
 (Signed) **P. E. James**, M. D.
Nov. 1, 1914 (Address) **Sharpstown, Md.**

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.
 Where was disease contracted, If not at place of death?
 Former or usual residence

19 PLACE OF BURIAL OR REMOVAL **Iron Church** DATE OF BURIAL **Nov 14, 1914**

20 UNDERTAKER **W. A. Gravelor** ADDRESS **Pro Sharpstown**

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

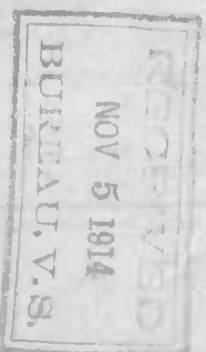
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Idiotion," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 10381
County Micomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 338

Village or City Hebron (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Henry C. Gilliss

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Aug 14, 1891
(Month) (Day) (Year)

7 AGE 23 yrs. 2 mos. 17 ds. If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work Street car conductor
(b) General nature of industry, business, or establishment in which employed (or employer) 11 11

9 BIRTHPLACE (State or country) Micomico Co

10 NAME OF FATHER G. C. Gilliss

11 BIRTHPLACE OF FATHER (State or country) Micomico Co

12 MAIDEN NAME OF MOTHER Lizzie Calloway

13 BIRTHPLACE OF MOTHER (State or country) Micomico Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. C. Gilliss

(Address) Hebron Md

15 Filed _____, 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 31, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw him alive on _____, 191____

and that death occurred on the date stated above, at _____ m,

The CAUSE OF DEATH* was as follows:

Revolver wound of head
Suicide

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) H. C. Conaway, M. D.

Nov 3, 1914 (Address) Hebron Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Mardella Springs Nov 3, 1914

20 UNDERTAKER ADDRESS

Geo. C. Hill Salisbury

Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

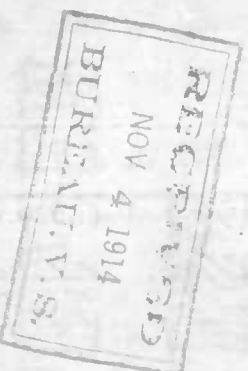
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercle*s of *lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile" etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and quality as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH		10382		STATE OF MARYLAND	
County <u>Wicomico</u>		(40)		CERTIFICATE OF DEATH	
Village or City <u>Salisbury Ind.</u>		(No. <u>Camden St.</u>)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>John W. Hall</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>			
6 DATE OF BIRTH <u>Aug. 10th</u> , 191 <u>4</u> (Month) (Day) (Year)					
7 AGE <u>6-6</u> yrs. <u>2</u> mos. <u>2</u> ds. OR <u>1</u> day.....hrs. IT LESS than 1 day.....hrs.					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Laborer</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Maryland</u>					
PARENTS					
10 NAME OF FATHER <u>Fleet Hall</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Washington D. C.</u>					
12 MAIDEN NAME OF MOTHER <u>Leah A. Adams</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs. John W. Hall</u> (Address) <u>Salisbury Ind.</u>					
15 Filed <u>Oct 19</u> , 191 <u>4</u> <u>M. Burner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct-19th</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept-15</u> , 191 <u>4</u> , to <u>Oct-19</u> , 191 <u>4</u> , that I last saw him alive on <u>Oct-1</u> , 191 <u>4</u> , and that death occurred on the date stated above, at <u>12</u> m. The CAUSE OF DEATH* was as follows: <u>on lung</u> <u>on lung</u> (Duration) <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds. Contributory Secondary <u>Dropsy. Heart failure</u> (Duration) <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds. (Signed) <u>Grandin Spring</u> , M. D. <u>Oct-19</u> , 191 <u>4</u> . (Address) <u>Salisbury Ind.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, OF HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds. In the State <u>1</u> yrs. <u>2</u> mos. <u>2</u> ds. Where was disease contracted, If not at place of death? Former or usual residence.					
19 PLACE OF BURIAL OR REMOVAL <u>Parson Cemetery Salisbury Ind.</u> DATE OF BURIAL <u>Oct 19</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Geo. C. Hill</u> ADDRESS <u>Salisbury Ind.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Cancer*,

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 5 1914
BUREAU. V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH <u>10383</u>		STATE OF MARYLAND	
County <u>Wicomico</u>		CERTIFICATE OF DEATH	
Village or City <u>near Fruitland</u> (No. <u>Camden Dist.</u> St. <u>13</u> Ward)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Benjamin Handy</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>male</u>	4 COLOR OR RACE <u>a. a.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>June 21, 1846</u> (Month) (Day) (Year)			
7 AGE <u>68</u> yrs. <u>4</u> mos. <u>6</u> ds. If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland</u>			
PARENTS	10 NAME OF FATHER <u>Hanson Daughfield</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Shorlet Johnson</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE			
(Informant) <u>John Handy</u>			
(Address) <u>Fruitland, Md.</u>			
15 Filed <u>Oct. 10, 1914</u> <u>May Turner</u> Deputy REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>10th 8th, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Sept. 30th, 1914</u> , to <u>Oct. 8th, 1914</u> , that I last saw him alive on <u>Oct. 7th, 1914</u> , and that death occurred on the date stated above, at <u>5th A. M.</u>			
The CAUSE OF DEATH* was as follows: <u>Paralysis of intestines from chronic gastro-enteritis</u>			
(Duration) <u>3</u> yrs. mos. ds.			
Contributory <u>Indiscretion of diet</u> Secondary <u>for some time</u>			
(Signed) <u>J. W. Roberts</u> , M. D. <u>Oct. 11th, 1914</u> (Address) <u>Salisbury, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>68</u> yrs. <u>4</u> mos. <u>6</u> ds. In the <u>68</u> yrs. <u>4</u> mos. <u>6</u> ds. Where was disease contracted, <u>at school</u> If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL <u>Fruitland Cemetery</u>		DATE OF BURIAL <u>Oct. 10, 1914</u>	
20 UNDERTAKER <u>H. Stewart</u>		ADDRESS <u>Salisbury, Md.</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubercular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
NOV 5 1914
BUREAU V. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH, 10384
County Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City Salisbury (No. Camden Dist. St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Richard Corbett Harris

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH May 12th, 1912
(Month) (Day) (Year)

7 AGE 1 yrs. 4 mos. 22 ds. OR 1 day.....hrs. OR 1 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work. None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Salisbury Md.

10 NAME OF FATHER Lemuel James Harris

11 BIRTHPLACE OF FATHER (State or country) Worcester Co. Md.

12 MAIDEN NAME OF MOTHER Eliza J. Corbett

13 BIRTHPLACE OF MOTHER (State or country) Virginia

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) L. Harris

(Address) 657 Jackson St. Salisbury Md.

15 Filed Oct. 5, 1914 May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 4, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 2, 1914, to Oct 4, 1914,
that I last saw him alive on Oct 4, 1914.

and that death occurred on the date stated above, at 3:15 P. m.

The CAUSE OF DEATH* was as follows:

Ileo Colitis

(Duration) yrs. mos. 33 ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) W. B. Burns, M. D.
Oct 5, 1914 (Address) Salisbury

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Parsons Cem Salisbury Md. DATE OF BURIAL Oct 5th, 1914

20 UNDERTAKER Geo. L. Hill ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

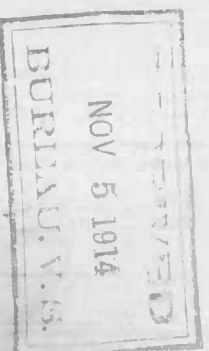
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL, septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH		10385		STATE OF MARYLAND	
County <u>Wicomico</u>		(37)		CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u>		(No. <u>311</u> , <u>Water</u>)		Registration Dist. No. <u>333</u> .	
2 FULL NAME <u>Morris R. Henry</u>				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	

PERSONAL AND STATISTICAL PARTICULARS						MEDICAL CERTIFICATE OF DEATH					
3 SEX <u>Male</u>		4 COLOR OR RACE <u>a.a.</u>		5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>single</u>		16 DATE OF DEATH <u>Oct. 23</u> , 191 <u>4</u> (Month) (Day) (Year)					
6 DATE OF BIRTH <u>March 29</u> , 191 <u>3</u> (Month) (Day) (Year)						17 I HEREBY CERTIFY, That I attended deceased from <u>Jan. 22</u> , 191 <u>4</u> , to <u>Oct. 22</u> , 191 <u>4</u> , that I last saw him alive on <u>Aug. 25</u> , 191 <u>4</u>					
7 AGE <u>1</u> yrs. <u>6</u> mos. <u>25</u> ds. OR <u>1</u> day, <u>25</u> hrs. <u>59</u> min. ?						and that death occurred on the date stated above, at <u>5 a.</u> m. The CAUSE OF DEATH* was as follows: <u>Hereditary Syphilis</u> (Duration) <u>1</u> yrs. <u>6</u> mos. <u>23</u> ds.					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>patamy</u> (b) General nature of industry, business, or establishment in which employed (or employer)						Contributory Secondary					
9 BIRTHPLACE (State or country) <u>Maryland</u>						(Duration) <u>1</u> yrs. <u>6</u> mos. <u>23</u> ds.					
10 NAME OF FATHER <u>Not known</u>						(Signed) <u>J. W. Roberts</u> , M. D. <u>Oct. 23</u> , 191 <u>4</u> (Address) <u>Salisbury Md.</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>						*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
12 MAIDEN NAME OF MOTHER <u>Edna E. Henry</u>						18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>1</u> yrs. <u>6</u> mos. <u>23</u> ds. In the State <u>1</u> yrs. <u>6</u> mos. <u>23</u> ds.					
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>						Where was disease contracted, If not at place of death? Former or usual residence <u>Salisbury</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mary E. Henry</u> (Address) <u>Salisbury Md.</u>						19 PLACE OF BURIAL OR REMOVAL <u>Hanston Cemetery</u>					
15 Filed <u>Oct. 22</u> , 191 <u>4</u> <u>May Turner</u> Deputy REGISTRAR						DATE OF BURIAL <u>Oct 23</u> , 191 <u>4</u>					
						20 UNDERTAKER <u>L. Stewart</u> <u>Salisbury Md.</u>					

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

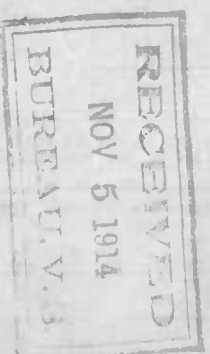
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1 PLACE OF DEATH 10386

County

Meonies

Village or City

Sharptown

(No.

St.;

Ward)

2 FULL NAME

George H. Hitch

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDDED,
ORDIVORCED
(Write the word)

Married

6 DATE OF BIRTH

Aug 13, 1843

(Month)

(Day)

(Year)

7 AGE

71 yrs. 1 mos. 22 ds.

It LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work

Farmer

(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Delaware

PARENTS

10 NAME OF
FATHER

Benjamin Hitch

11 BIRTHPLACE
OF FATHER
(State or country)

Delaware

12 MAIDEN NAME
OF MOTHER

Urania Armstrong

13 BIRTHPLACE
OF MOTHER
(State or country)

Delaware

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jennie Hitch

(Address)

Sharptown

15

Filed

10/7

1914

W. C. Mann

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

335

[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Sept 5, 1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

July 1, 1913, to Oct. 5, 1914.

that I last saw him alive on Aug. 15, 1914.

and that death occurred on the date stated above, at 2 P. M.

The CAUSE OF DEATH* was as follows:

Chronic Gastritis

(Duration) 3 yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. E. Jones

, M. D.

Oct 7, 1914 (Address)

Sharptown

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL,
SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
It not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

St. Marks Church.

Oct 7, 1914

20 UNDERTAKER

ADDRESS

W. D. Gravenor & Son Sharptown.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

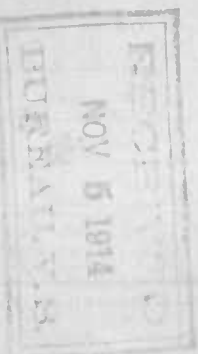
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carboic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10387

STATE OF MARYLAND
CERTIFICATE OF DEATHCounty MicromCamden Dist.Registration Dist. No. 333Village or City Salisbury(No. P. G. Hospital)St.; 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Not named Homer

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

G. A.

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Single

6 DATE OF BIRTH

Oct. 29, 1914
(Month) (Day) (Year)

7 AGE

Still born
yrs. mos. ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work.

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country)

Salisbury

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER (State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Ardesen Homer

13 BIRTHPLACE OF MOTHER (State or country)

Know Hill Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Ray Mc Beck

(Address)

Salisbury Md

15

Filed

Oct. 30, 1914 Inay Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 29, 1914, to Oct 29, 1914.that I last saw him alive on Still born, 1914.and that death occurred on the date stated above, at 8:30 m.

The CAUSE OF DEATH* was as follows:

Still born

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) Mc Beck, M. D.Oct. 30, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Salisbury Center, Oct 30, 1914

20 UNDERTAKER

ADDRESS

Dr. Mc Beck Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

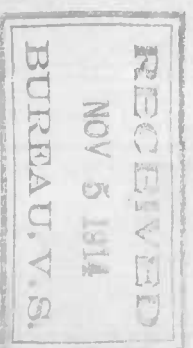
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Former (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential, and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10388

County WicomicoVillage or City Sharptown (No. _____)

St.; _____ Ward)

Registration Dist. No. 335

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Did before named

PERSONAL AND STATISTICAL PARTICULARS

3 SEX female 4 COLOR OR RACE white 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single
(Write the word)

6 DATE OF BIRTH Oct 29, 1914
(Month) (Day) (Year)

7 AGE _____ yrs. _____ mos. _____ ds. It LESS than 1 day, _____ hrs. OR 15 min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work none
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) md

10 NAME OF FATHER James Walter Hughes

11 BIRTHPLACE OF FATHER (State or country) md

12 MAIDEN NAME OF MOTHER Helen Frieda Frayer

13 BIRTHPLACE OF MOTHER (State or country) Minnesota

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) James Walter Hughes(Address) Sharptown, md

15 Filed 10/31, 1914 W. C. Mannis
REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 29, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 29, 1914, to Oct 29, 1914

that I last saw her alive on Oct 29, 1914

and that death occurred on the date stated above, at 7.15 P. m.

The CAUSE OF DEATH* was as follows:

Premature Birth

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) C. E. James, M. D.

11/30, 1914. (Address) Sharptown, md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Near Sharptown DATE OF BURIAL Oct. 31, 1914

20 UNDERTAKER W. S. Gravenor & Co ADDRESS Sharptown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

Approved by U. S. Census and American Public Health Association.¹

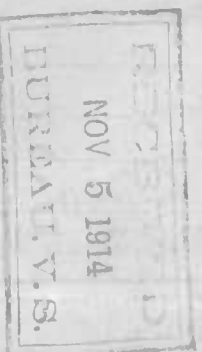
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Hantion," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH **10389**
County Micromie

Village or City Salisbury (No. 104) Parsons list St. 51 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 323

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Edward G. Humphreys

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH Jan 1, 1914
(Month) (Day) (Year)

7 AGE 9 yrs. 28 mos. 28 ds. OR 1 day, 28 hrs. 28 min. ?
It LESS than

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Micromie Co

PARENTS
10 NAME OF FATHER G. R. Humphreys
11 BIRTHPLACE OF FATHER (State or country) Micromie Co
12 MAIDEN NAME OF MOTHER Mary L. Gordy
13 BIRTHPLACE OF MOTHER (State or country) Micromie Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) G. R. Humphreys

(Address) Salisbury Md

15 Filed Oct 28, 1914 M. Turner
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 28, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 15, 1914, to Oct 28, 1914, that I last saw him alive on Oct 27, 1914

and that death occurred on the date stated above, at 3 A m.
The CAUSE OF DEATH* was as follows:

Illeg Colitis

(Duration) 2 yrs. — mos. — ds.

Contributory Exhaustion
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) B. B. Potter, M. D.
Oct 28, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death — yrs. — mos. — ds. In the State — yrs. — mos. — ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Potter Field Salisbury DATE OF BURIAL Oct 28, 1914

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

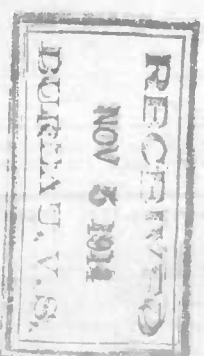
Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite): *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Delirium" ("Congitial," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for

which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10390

County

Micomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 330

Village or City

Mardela Spgs

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

(Still-Born child)

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Black

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Oct 5, 1914
(Month) (Day) (Year)

7 AGE

0 yrs. 0 mos. 1 ds.

If LESS than
1 day, hrs.
OR min. ?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Md

PARENTS

10 NAME OF
FATHER

Elgie Johnson

11 BIRTHPLACE
OF FATHER
(State or country)

Md

12 MAIDEN NAME
OF MOTHER

Nellie Winder

13 BIRTHPLACE
OF MOTHER
(State or country)

Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elgie Johnson

(Address)

Mardela

15

Filed Nov 2, 1914 J. L. English

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

10 5, 1914
(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

, 191, to , 191,

that I last saw h. alive on , 191

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

(Still-Born)

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

Spence L. English Reg. M. D.
, 191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Pea Hill

10/31, 1914

20 UNDERTAKER

ADDRESS

Elgie Johnson

Mardela

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

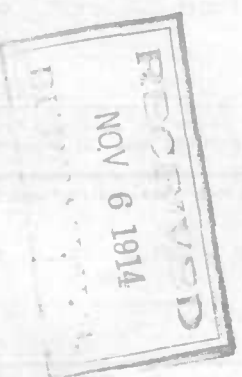
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Loobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 10391

County

Wisconsin

Village or City

Sharptown

(No.)

St.; Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

335

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Johnny T. Jones

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE,
MARRIED,
WIDOWED,
ORDIVORCED
(Write the word)

6 DATE OF BIRTH

Oct 9, 1914
(Month) (Day) (Year)

7 AGE

yrs. mos. 21 ds. OR 1 day, hrs. min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Sharptown

PARENTS

10 NAME OF FATHER

John T. Jones

11 BIRTHPLACE OF FATHER
(State or country)

Md.

12 MAIDEN NAME OF MOTHER

Mary E. Fletcher

13 BIRTHPLACE OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

John T. Jones

(Address)

Sharptown, Md.

15

Filed

10/9/14 H. G. Mann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 30, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Oct 9, 1914, to Oct 30, 1914,
that I last saw him alive on Oct 30, 1914.

and that death occurred on the date stated above, at 11 A. m.

The CAUSE OF DEATH* was as follows:

Cleft. Palate

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

C. E. Jones, M. D.

191 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Sharptown, Md.

Oct 31, 1914

20 UNDERTAKER

ADDRESS

H. G. Gavenor & Bro Sharptown

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

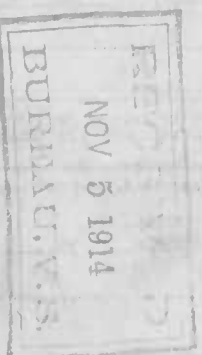
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Saltman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name organ; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis" etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10392		STATE OF MARYLAND	
County McDermott Md		CERTIFICATE OF DEATH	
Village or City Keardelmar (No. 103)		Registration Dist. No. 336	
2 FULL NAME Samuel Waples Kenney		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married (Write the word)	
6 DATE OF BIRTH 3 22 1859 (Month) (Day) (Year)			
7 AGE 55 yrs. 4 mos. 13 ds.		If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work Farmer (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) Delaware			
PARENTS	10 NAME OF FATHER Samuel Kenney		
	11 BIRTHPLACE OF FATHER (State or country) Delaware		
	12 MAIDEN NAME OF MOTHER Julia Kenney		
	13 BIRTHPLACE OF MOTHER (State or country) Delaware		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs. Martha Kenney (Address) Pemmar Dela			
15 Filed Oct 6 1914 W. J. Quinn REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH 10 5 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from September 23 , 1914, to Oct 5 , 1914, that I last saw him alive on Oct 5th , 1914, and that death occurred on the date stated above, at 11 A.M. The CAUSE OF DEATH* was as follows: Dysentery (Duration) yrs. mos. ds. 15 Contributory Rheumatism Secondary (Duration) yrs. mos. ds. 3			
(Signed) James Brayshear , M. D. Oct 5th , 1914. (Address) Delmar Del.			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, If not at place of death? Former or usual residence			
19 PLACE OF BURIAL OR REMOVAL L. Hastings Cemetery		DATE OF BURIAL October 7, 1914	
20 UNDERTAKER Mrs. S. Marvel		ADDRESS Delmar	
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

keela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

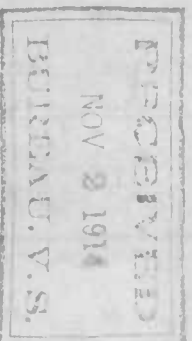
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faintfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theina," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Thremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		10393 (138)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>P.G. Hospital</u> St. <u>13</u> Ward)		Registration Dist. No. <u>333</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Harriet Mason</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>A.G.</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>			
6 DATE OF BIRTH <u>Feb. 15, 1890</u> (Month) (Day) (Year)		7 AGE <u>24</u> yrs. <u>9</u> mos. <u>12</u> ds. OR LESS than 1 day.....hrs. OR.....min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housework</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Virginia</u>					
PARENTS	10 NAME OF FATHER <u>Henry Mason</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Virginia</u>				
	12 MAIDEN NAME OF MOTHER <u>Agnes Duff</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Virginia</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Maggie Bailey</u> (Address) <u>Tasley Dr</u>					
15 Filled <u>Oct 30</u> , 191 <u>4</u> <u>M. Burner</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct. 29, 1914</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 27, 1914</u> to <u>Oct. 29, 1914</u> , that I last saw her alive on <u>Oct. 29, 1914</u> and that death occurred on the date stated above, at <u>4 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Pulmonary edema</u>					
Contributory (Duration) yrs. mos. <u>3</u> ds. Secondary <u>Scumpkin</u>					
(Signed) <u>M. Burner</u> , M. D. <u>Oct 30, 1914</u> (Address) <u>Salisbury Md</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death yrs. mos. ds. In the State yrs. mos. ds. Where was disease contracted, <u>Virginia</u> If not at place of death? Former or usual residence <u>Virginia</u>					
19 PLACE OF BURIAL OR REMOVAL <u>McClintock Rd</u>				DATE OF BURIAL <u>Oct 31, 1914</u>	
20 UNDERTAKER <u>J. H. Stewart Salisbury Md</u>				ADDRESS	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

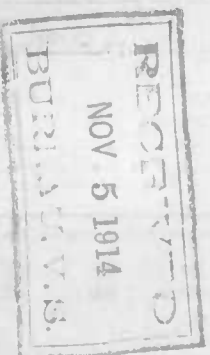
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Statement of cause of death—Name, first, the DISEASE CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal, septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 10394
County Wicomico

Village or City Pulmar (No. _____) St. _____ Ward _____

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 336

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Nancy Elizabeth Nelson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Widowed

6 DATE OF BIRTH

5 (Month) 11 (Day), 1838 (Year)

7 AGE

81 yrs. 4 mos. 25 ds. OR 1 day, _____ hrs. OR _____ min. ?

If LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

House Keeper

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Delaware

PARENTS

10 NAME OF FATHER

John A. Parsons

11 BIRTHPLACE OF FATHER (State or country)

Dont Know

12 MAIDEN NAME OF MOTHER

Dont Know

13 BIRTHPLACE OF MOTHER (State or country)

Dont Know

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Eligah J. Nelson

(Address)

Pulmar Dela

15

Filed Oct 8 1914 Wm J. Dunn

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct (Month) 5 (Day), 1914 (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 29, 1914, to Oct 5, 1914,

that I last saw her alive on Oct 5, 1914,

and that death occurred on the date stated above, at 9:30 P m.

The CAUSE OF DEATH* was as follows:

Senile Debility

Contributory
Secondary

(Duration) 2 yrs. _____ mos. _____ ds.

(Duration) 2 yrs. _____ mos. _____ ds.

(Signed)

Robert Ellwood, M. D.

Oct 8, 1914. (Address) Pulmar Del

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18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence.

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Delmar M. Cemetery October 9, 1914

20 UNDERTAKER

ADDRESS

Wm J. Marvel Pulmar Dela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

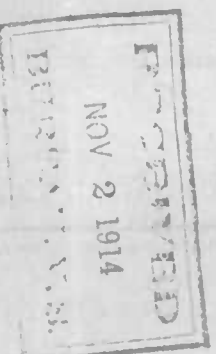
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1 PLACE OF DEATH

10395

County

W. Conner
P. G. Hospital

Village or City

Salisbury (No. Cambridge St. 13 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Betsey Miles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

Caucasian

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Unknown

(Month) (Day) (Year)

7 AGE

about 45

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

Housewife

9 BIRTHPLACE

(State or country)

McCombs Co. Md

PARENTS

10 NAME OF FATHER

Henry Thomas

11 BIRTHPLACE OF FATHER

(State or country)

McCombs Co. Md

12 MAIDEN NAME OF MOTHER

Catherine Thomas

13 BIRTHPLACE OF MOTHER

(State or country)

McCombs Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Jack Miles

(Address)

Princes Anne Md

15

Filed

Oct 21 1914 M. Gurner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 20, 1914

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 18, 1914, to Oct. 20, 1914,

that I last saw him alive on Oct. 20, 1914,

and that death occurred on the date stated above, at 8 P. m.

The CAUSE OF DEATH* was as follows:

Acute nephritis

(Duration) yrs. mos. ds.

Contributory Secondary

Pulmonary edema

(Duration) yrs. mos. ds.

(Signed)

Oct 20, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Princes Anne Md Oct 22, 1914

20 UNDERTAKER

ADDRESS

James L. Gurner Princes Anne Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

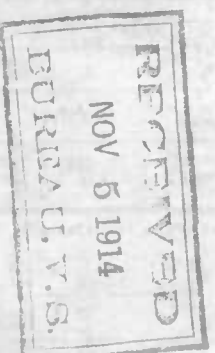
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer." "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Reverber wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH

10396

County

Wicomico

Pine Bluff Sanatorium Near Salisbury Md.

Village or City

(No.

Camden Dist

Registration Dist. No.

333

St. 13 Ward

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James H. Moiles

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
6 DATE OF BIRTH Don't know		
(Month) (Day) (Year)		
7 AGE About 44 yrs.		If LESS than 1 day, hrs. OR min.?

8 OCCUPATION

(a) Trade, profession, or particular kind of work. Telephone Lineman
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)

Lowell Mass.

PARENTS

10 NAME OF FATHER

Unknown

11 BIRTHPLACE OF FATHER
(State or country)

Unknown

12 MAIDEN NAME OF MOTHER

Unknown

13 BIRTHPLACE OF MOTHER
(State or country)

Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. H. Ross

(Address)

Princess Anne Md.

15

File Oct 9 1914 N. B. Turner

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct 9

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Sept. 9 1914 to Oct 9 1914

that I last saw him alive on Oct 8 1914

and that death occurred on the date stated above, at 3.30 A. M.

The CAUSE OF DEATH* was as follows:

Expansion of Pulmonary Tuberculosis
(Duration) Don't know ds.

Contributory
Secondary

Tuberculosis (Duration) Don't know ds.

(Signed) Dr. H. L. Laid M. D.

Oct. 9 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 30 ds. In the State yrs. mos. ds.

Where was disease contracted, Don't know

If not at place of death?

Former or usual residence Lowell Mass

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Princess Anne Md.

Oct. 12 1914

20 UNDERTAKER Shipped by

ADDRESS

Geo. C. Hall

Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

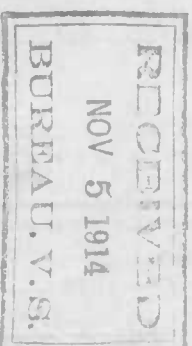
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH 10397		STATE OF MARYLAND	
County Wicomico		CERTIFICATE OF DEATH	
Village or City Salisbury (No. Parsons Dist.)		Registration Dist. No. 333	
2 FULL NAME Zora S Moore		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX male	4 COLOR OR RACE Colored	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED single (Write the word)	
6 DATE OF BIRTH Aug 3, 1914 (Month) (Day) (Year)			
7 AGE 2 yrs 14 mos If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) Md.			
PARENTS			
10 NAME OF FATHER Zora H Moore			
11 BIRTHPLACE OF FATHER (State or country) Md.			
12 MAIDEN NAME OF MOTHER Mary E Turner			
13 BIRTHPLACE OF MOTHER (State or country) Md.			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Zora S Moore (Address) Salisbury Md.			
15 Filed Oct. 12, 1914 May Turner Deputy REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH Oct 17, 1914 (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____.			
that I last saw him _____ alive on _____, 191____.			
and that death occurred on the date stated above, at _____ m.			
The CAUSE OF DEATH* was as follows: Had no port for pulmonary embolism died from improper food (Duration) _____ yrs. _____ mos. _____ ds.			
Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds.			
(Signed) ORRANT , M. D. Oct 17, 1914 (Address) Salisbury Md.			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL Rockaway		DATE OF BURIAL Oct 17, 1914	
20 UNDERTAKER Hallam & Co		ADDRESS Salisbury	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

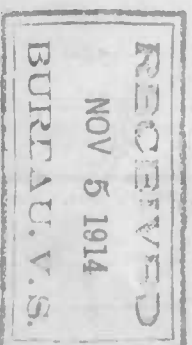
[Approved by U. S. Census and American Public Health Association.]

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1 PLACE OF DEATH

10398

County

Anconico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

337

Village or City

Nauticoske

(No.)

St.;

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Theodore R. Mitter

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

C

5 SINGLE,
MARRIED,
WIDOWED,
OR DIVORCED
(Write the word)

6 DATE OF BIRTH

Sept

23

1914

7 AGE

1 yrs. 10 mos. 10 ds.

If LESS than
1 day.....hrs.
OR.....min.?

8 OCCUPATION

(a) Trade, profession, or
particular kind of work(b) General nature of industry,
business, or establishment in
which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

10 NAME OF
FATHER

Clarence Mitter

11 BIRTHPLACE
OF FATHER
(State or country)

Maryland

12 MAIDEN NAME
OF MOTHER

Marriett Mitter

13 BIRTHPLACE
OF MOTHER
(State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Clarence Mitter

(Address)

Nauticoske Rd

15

Filed

Sept. 27th, 1914

L. J. Malthus

Local

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct

27

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

1914 to 1914

that I last saw him alive on 1914

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH* was as follows:

No Physician in
attendance

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed) L. J. Malthus, M. D.

Oct 31st, 1914 (Address) Nauticoske, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,
If not at place of death?Former or
usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Cotrel cemetery, Baltimore Oct 28, 1914

20 UNDERTAKER

ADDRESS

C. G. Malthus Bivalve Rd

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH

10399

County

Wicomico

Parronsburg

Village or City

Parronsburg

(No.)

St.; Ward)

Registration Dist. No. 332

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Robert A Parker

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

1844

7 AGE

70

It LESS than 1 day, hrs. yrs. mos. ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

Sampson Parker

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Sallie Lewis

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Will Parker

(Address)

Parronsburg

15

Filed

191

REGISTRAR

STATE OF MARYLAND
CERTIFICATE OF DEATH

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct

17

1914

(Month) (Day) (Year)

17

I HEREBY CERTIFY, That I attended deceased from

Aug 21

1914

to Sept 23

1914

that I last saw him alive on

Sept 23

1914

and that death occurred on the date stated above, at

6:30 A. m.

The CAUSE OF DEATH* was as follows:

Left Hemiplegia

(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.

(Signed)

L. C. Green

M. D.

Oct 20

1914

(Address) Pittsboro, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place

of death

yrs. mos. ds.

In the

State

yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or

usual residence

11

19 PLACE OF BURIAL OR REMOVAL

Parronsburg church cemetery

DATE OF BURIAL

October 18, 1914

20 UNDERTAKER

J. R. H. Harlow

ADDRESS

Wicomico, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

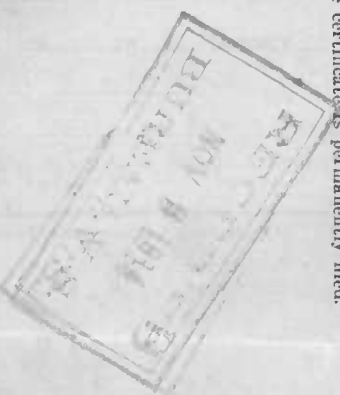
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not faithfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-theia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10400
County Waldston

Village or City Waldston (No. 104 Parsonsdist St.; 1 Ward)

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lula E Parsons

PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female White</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
6 DATE OF BIRTH <u>Jan 7</u> , 1913 (Month) (Day) (Year)		
7 AGE <u>1</u> yrs. <u>8</u> mos. <u>6</u> ds.		If LESS than 1 day.....hrs. OR.....min. ?
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Home</u> (b) General nature of industry, business, or establishment in which employed (or employer)		
9 BIRTHPLACE (State or country) <u>Md</u>		

PARENTS	10 NAME OF FATHER <u>Elijah H Parsons</u>
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>
	12 MAIDEN NAME OF MOTHER <u>Lula A Taylor</u>
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Elijah H Parsons

(Address) Salisbury Md

15 Filed Oct 14, 1914 M. B. Bunker
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 13, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 5, 1914, to Oct 5, 1914

that I last saw her alive on Oct 5, 1914

and that death occurred on the date stated above, at 5 P m.

The CAUSE OF DEATH* was as follows:

Gastro Enteritis
(Duration) yrs. mos. ds.

Contributory
Secondary

(Duration) yrs. mos. ds.
(Signed) E R Tamm, M. D.
Oct 14, 1914 (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Waldston DATE OF BURIAL Oct 14, 1914

20 UNDERTAKER Holloway & Co ADDRESS Salisbury Md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

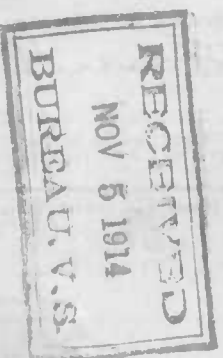
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congitinal," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Træmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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¹ PLACE OF DEATH **10401**
County Wicomico

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 334

Village or City Salisbury (No. _____, St.; _____ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

² FULL NAME Sarah E. Pearson

PERSONAL AND STATISTICAL PARTICULARS

³ SEX Female ⁴ COLOR OR RACE White ⁵ SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

⁶ DATE OF BIRTH April 3rd, 1832
(Month) (Day) (Year)

⁷ AGE 82 yrs. 6 mos. 1 ds. OR min. ?
If LESS than 1 day, hrs.

⁸ OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

⁹ BIRTHPLACE (State or country) Cecil County Md.

PARENTS
¹⁰ NAME OF FATHER Samuel Wothers
¹¹ BIRTHPLACE OF FATHER (State or country) Not known
¹² MAIDEN NAME OF MOTHER Sallie Nowland
¹³ BIRTHPLACE OF MOTHER (State or country) Maryland

¹⁴ THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Robert D. W. Pearson

(Address) 422 Lake Street

¹⁵ Filed Oct. 6, 1914

J. Rodney Jones REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

¹⁶ DATE OF DEATH Oct 8, 1914
(Month) (Day) (Year)

¹⁷ I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____,

that I last saw her alive on Sept. 13, 1914

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

When I saw her she was suffering from general debility & debility
(Duration) _____ yrs. _____ mos. _____ ds.

Contributory None known
Secondary _____

(Signed) Dr. H. D. H. D.
Oct 5, 1914 (Address) Salisbury Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

¹⁸ LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted; If not at place of death?

Former or usual residence _____

¹⁹ PLACE OF BURIAL OR REMOVAL Westover Lom. Co. Md. DATE OF BURIAL Oct. 7th, 1914

²⁰ UNDERTAKER Geo. C. Hill ADDRESS Salisbury Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

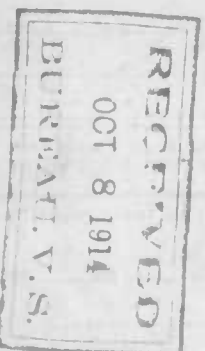
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Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH 10402

County WicomicoVillage or City Salisbury (No. Hospital)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Arnold Pills-

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE Black 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) widower

6 DATE OF BIRTH unknown, 1 (Month) (Day) (Year)

7 AGE About 48 yrs. (Month) (Day) (Year) If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer) none

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Plater Taylon

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Phetty Taylor

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Ella Tholland(Address) Berlin md

15 Filed Oct. 23, 1914 Gray Turner REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 23, 1914 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 14, 1914, to Oct. 23, 1914.

that I last saw him alive on Oct. 23, 1914.

and that death occurred on the date stated above, at 6 P m.

The CAUSE OF DEATH* was as follows:

Older many old

Contributory acute nephritis (Duration) yrs. mos. plus

Secondary (Duration) yrs. mos. 6 ds.

(Signed) Medin, M. D.

Oct 23, 1914 (Address) Salisbury md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. 16 ds. In the State Lifetime yrs. mos. ds.

Where was disease contracted, Worcester, ms

If not at place of death? Worcester, ms

Former or usual residence Worcester, ms

19 PLACE OF BURIAL OR REMOVAL Berlin md DATE OF BURIAL Oct 25, 1914

20 UNDERTAKER Lewis J. Evans ADDRESS Berlin md

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

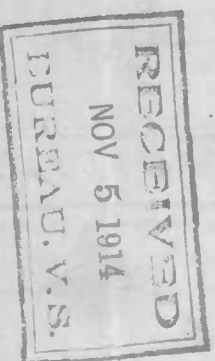
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH 10403
County Nicomis

Village or City Sharpton (No. 120)

2 FULL NAME Emma L. Quinton

STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 335

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE Col 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married
(Write the word)

6 DATE OF BIRTH Sept 10, 1935
(Month) (Day) (Year)

7 AGE 79 yrs. 1 mos. 10 ds. OR 1 day, hrs. min. ?
It LESS than 1 day, hrs. min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Housewife
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Dorchester Co.

10 NAME OF FATHER Daniel Sampson

11 BIRTHPLACE OF FATHER (State or country) Dorchester Co

12 MAIDEN NAME OF MOTHER Sallie Barnett.

13 BIRTHPLACE OF MOTHER (State or country) Dorchester Co

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Chas Quinton

(Address) Sharpton

15 Filed 9/20, 194 W C Mann

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 20, 194
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 13, 194, to Oct 20, 194,
that I last saw her alive on Oct 13, 194,

and that death occurred on the date stated above, at 6:30 p.m.
The CAUSE OF DEATH* was as follows:

Chronic Diffuse Nephritis
(Duration) 2 yrs. mos. ds.

Contributory General Debility
Secondary (Duration) yrs. mos. ds.

(Signed) C. E. James, M. D.
Oct 21, 194 (Address) Sharpton, Md.

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

Shiloh Church.

DATE OF BURIAL

Oct 22, 194

20 UNDERTAKER

W. S. Graves & Bro.

ADDRESS

Sharpton, Md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer*, or *Plumber*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The statement worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic interstitial nephritis*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Trauma," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH 10404
County Wicomico

Village or City Salisbury (No. Canden Dist St. 13 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Catherine M. Riffin

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed
(Write the word)

6 DATE OF BIRTH May 29th, 1834
(Month) (Day) (Year)

7 AGE 80 yrs. 4 mos. 19 ds. 1 LESS than
day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work None
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Daniel Johnson

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Catherine Collins

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Riffin
(Address) Salisbury, Md

15 Filed Oct. 19, 1914 May Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 18, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct 1, 1914, to Oct 18, 1914

that I last saw her alive on Oct 17, 1914

and that death occurred on the date stated above, at 7 p. m.

The CAUSE OF DEATH* was as follows:

Senile fallacy
Bright's disease

Since first of Oct for
(Duration) yrs. mos. ds.

Contributory personal knowledge
Secondary

(Duration) yrs. mos. ds.

(Signed) J. S. Wells, M. D.

Oct 19, 1914 (Address) Salisbury, Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Shad Point M. E. Churchyard Oct. 20th, 1914

20 UNDERTAKER ADDRESS

Geo. C. Heill Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

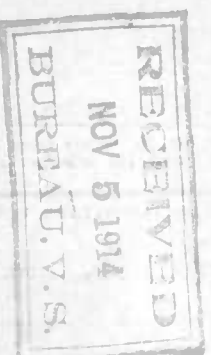
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		10405	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Near Maryland</u>		(No. <u>189</u>)	Registration Dist. No. <u>330</u>	
2 FULL NAME <u>Infant Child</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]		
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)		
6 DATE OF BIRTH <u>Aug 26</u> , 1914 (Month) (Day) (Year)				
7 AGE _____ yrs. <u>2</u> mos. <u>1</u> ds.		If LESS than 1 day, _____ hrs. OR _____ min. ?		
8 OCCUPATION (a) Trade, profession, or particular kind of work (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Md</u>				
PARENTS				
10 NAME OF FATHER <u>Howard Robinson</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
12 MAIDEN NAME OF MOTHER <u>Lillian West</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>N Jersey</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE Informant <u>Howard Robinson</u> (Address) <u>Mardela Spgs</u>				
15 Filed <u>1</u> , 191_____ REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Oct 26</u> , 1914 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from _____, 191____, to _____, 191____, that I last saw him _____ alive on _____, 191____, and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Unknown</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory (Secondary) _____ (Signed) <u>J. L. English Reg</u> , M.D. (Address) _____, 191____ (Duration) _____ yrs. _____ mos. _____ ds.				
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. to the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Branch Hill Church</u>			DATE OF BURIAL <u>10/27</u> , 1914	
20 UNDERTAKER <u>H. L. Lehnare</u>			ADDRESS <u>Mardela</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

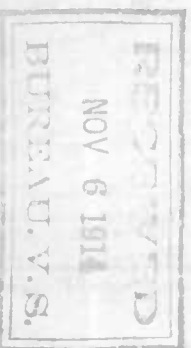
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death.—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc.. *Carcin-*

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1 PLACE OF DEATH

10406

(37)

County

Wilcomito

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

Village or City

Salisbury

(No. 208, Wilcomito

St. 13 Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

James E. Steggis

PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *a.a.* 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED *Single*
(Write the word)

6 DATE OF BIRTH *Aug 28, 1913*
(Month) (Day) (Year)

7 AGE *2 3* 1 LESS than
1 day, hrs. 2 mos. 3 ds. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Not any

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE
(State or country)*Maryland*

PARENTS

10 NAME OF FATHER

*William Steggis*11 BIRTHPLACE OF FATHER
(State or country)*Maryland*

12 MAIDEN NAME OF MOTHER

*Annie Waters*13 BIRTHPLACE OF MOTHER
(State or country)*Maryland*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

William Steggis

(Address)

Wilcomito St. Salisbury

15

Filed

*Oct 31st, 1914**1914**M. P. Burner*

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct. 31st, 1914
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from *Sept. 29th, 1914* to *Oct. 31st, 1914*that I last saw him alive on *Sept. 29th, 1914*and that death occurred on the date stated above, at *4 9. m.*

The CAUSE OF DEATH* was as follows:

*Hereditary Syphilis*Contributory
Secondary(Duration) *14* yrs. *14* mos. *14* ds.(Duration) *14* yrs. *14* mos. *14* ds.(Signature) *J. M. Roberts*, M. D.*Oct 31st, 1914* (Address) *Salisbury, Md.*

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death *4* yrs. *4* mos. *4* ds. In the State *4* yrs. *4* mos. *4* ds.

Where was disease contracted, If not at place of death?

Former or usual residence *Salisbury, Md.*

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Houston Cemetery Nov 1, 1914

20 UNDERTAKER

ADDRESS

L. H. Stewart Salisbury, Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

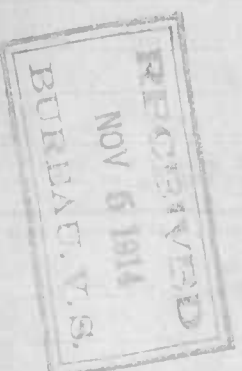
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oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		10407 (45)		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u>		(No. <u>Parsons list</u>)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Rebecca Swigert</u>		[It death occurred in a hospital or institution, give its NAME instead of street and number.]			
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>No Record</u> (Month) (Day) (Year)					
7 AGE <u>About 70</u> yrs. <u>0</u> mos. <u>0</u> ds. <u>0</u> min. ? It LESS than 1 day, hrs.					
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Not known</u>					
PARENTS	10 NAME OF FATHER <u>I dont know</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Unknown</u>				
	12 MAIDEN NAME OF MOTHER <u>I dont know</u>				
	13 BIRTHPLACE OF MOTHER (State or country) <u>Unknown</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Mrs L. D. Collier</u> (Address) <u>Salisbury Md.</u>					
15 FILED <u>Oct 10</u> , 191 <u>4</u> <u>M. M. M. M. M.</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 10</u> , 191 <u>4</u> (Month) (Day) (Year)					
I HEREBY CERTIFY, That I attended deceased from <u>Jan 12</u> , 191 <u>4</u> , to <u>Oct 10</u> , 191 <u>4</u> that I last saw h. <u>alive</u> on <u>Oct 7</u> , 191 <u>4</u> and that death occurred on the date stated above, at <u>1 A</u> m. The CAUSE OF DEATH* was as follows: <u>Carcinoma of neck</u> (Duration) <u>about 25 yrs.</u> ds. Contributory <u>Anemia & Exhaustion</u> Secondary (Duration) <u>40</u> yrs. <u>0</u> mos. <u>0</u> ds. (Signed) <u>M. M. M. M. M.</u> , M. D. <u>Oct 10</u> , 191 <u>4</u> (Address) <u>Salisbury Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death <u>5</u> yrs. <u>2</u> mos. <u>6</u> ds. In the State <u>Unknown</u> yrs. <u>0</u> mos. <u>0</u> ds. Where was disease contracted, <u>at place of death</u> It not at place of death? Former or usual residence <u>West Virginia</u>					
19 PLACE OF BURIAL OR REMOVAL <u>Parsons Cemetery Salisbury</u> DATE OF BURIAL <u>Oct 11</u> at <u>4 P.M.</u> , 191 <u>4</u>					
20 UNDERTAKER <u>Geo. C. Hill</u> ADDRESS <u>Salisbury</u>					

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
NOV 5 1914
BUREAU, U. S. S.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH **10408**
County Wicomico

Village or City Salisbury (No. Parsons Dist. St.; 5 Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No. 333

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Helen M. Vickers

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single

6 DATE OF BIRTH Dec 20, 1913
(Month) (Day) (Year)

7 AGE 0 yrs. 9 mos. 29 ds. 1 LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work.
(b) General nature of industry, business, or establishment in which employed (or employer)

None

9 BIRTHPLACE (State or country)

Wicomico Co. Md.

10 NAME OF FATHER

Charles Vickers

11 BIRTHPLACE OF FATHER (State or country)

Dorchester Co. Md.

12 MAIDEN NAME OF MOTHER

Cora Coffin

13 BIRTHPLACE OF MOTHER (State or country)

Worcester Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles Vickers

(Address) Salisbury Md.

15 Filed Oct. 19, 1914 Gray Turner
Deputy REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct. 19, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Oct. 10, 1914, to Oct. 19, 1914.

that I last saw her alive on Oct. 18, 1914

and that death occurred on the date stated above, at 4 A. m.

The CAUSE OF DEATH* was as follows:

Illus colitis

(Duration) one mos. ds.

Contributory
Secondary

Exhaustion

(Duration) one mos. ds.

(Signed) Exhaustion B. Potter, M. D.

Oct 17, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Public Cem. Salisbury Oct. 20th, 1914

20 UNDERTAKER

ADDRESS

Geo. C. Hill Salisbury

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

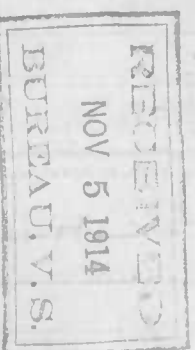
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congential," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent DEATHS state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH

10409

County WicomicoVillage or City Salisbury (No. _____)

St.; _____ Ward)

STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 334[If death occurred in
a hospital or institution,
give its NAME instead
of street and number.]

2 FULL NAME

Lambert A. Walson

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Married
(Write the word)

6 DATE OF BIRTH Sept. 5, 1889
(Month) (Day) (Year)

7 AGE 75 yrs. 0 mos. 27 ds. It LESS than 1 day, _____ hrs. OR _____ min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work Farmer
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Delaware

10 NAME OF FATHER George Walson

11 BIRTHPLACE OF FATHER (State or country) Delaware

12 MAIDEN NAME OF MOTHER Julia A. Moore

13 BIRTHPLACE OF MOTHER (State or country) Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Belmont Walson(Address) Salisbury Md

15

Filed Oct. 3, 1914Rodney Jones REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 2, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from Sept 18, 1914, to Oct 1, 1914,
that I last saw him alive on Oct 1, 1914.

and that death occurred on the date stated above, at 4:30 A. m.
The CAUSE OF DEATH* was as follows:

Myocardial Infarction
(Duration) _____ yrs. _____ mos. 12 ds.

Contributory Secondary Arteriosclerosis
(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) W. B. Burris, M. D.
10-2, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Parsonsbarn Salisbury Md. DATE OF BURIAL Oct. 5th, 1914 3 P.M.

20 UNDERTAKER Geo. C. Hill ADDRESS Salisbury

md.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

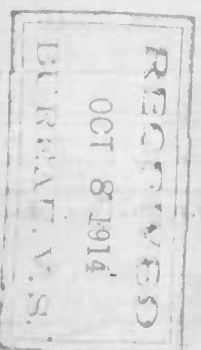
[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tubercles of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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6881
-34
7161

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH County <u>Wicomico</u> Village or City <u>Pittsville</u> (No. <u>80</u>)		STATE OF MARYLAND CERTIFICATE OF DEATH Registration Dist. No. <u>832</u>	
2 FULL NAME <u>Sallie W. Wells</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>Dec 2, 1840</u> (Month) (Day) (Year)			
7 AGE <u>73</u> yrs. <u>10</u> mos. <u>6</u> ds. <u>1</u> LESS than 1 day, ____ hrs. OR ____ min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>farmer</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Maryland, Wic.</u>			
PARENTS	10 NAME OF FATHER <u>William Truitt</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>		
	12 MAIDEN NAME OF MOTHER <u>Ellisbeth Truitt</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>			
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John W. Wells</u> (Address) <u>Pittsville, Md.</u>			
15 Filed _____, 191____			
REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Oct 8, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 8, 1914</u> , to <u>Oct 8, 1914</u> , that I last saw her alive on <u>Oct 8, 1914</u> , and that death occurred on the date stated above, at <u>6 P.</u> m.			
The CAUSE OF DEATH* was as follows: <u>Congestive Pectoria</u>			
<u>few hours (12)</u> (Duration) ____ yrs. ____ mos. ____ ds.			
Contributory Secondary			
(Signed) <u>L. C. Green</u> , M. D. <u>Oct 10, 1914</u> (Address) <u>Pittsville, Md.</u>			
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. ____ ds. In the State ____ yrs. ____ mos. ____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____			
19 PLACE OF BURIAL OR REMOVAL <u>Line Church, Conn.</u>		DATE OF BURIAL <u>October 10, 1914</u>	
20 UNDERTAKER <u>J. Battiff Harbor</u>		ADDRESS <u>Wicomico, Md.</u>	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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1 PLACE OF DEATH County <u>Wicomico</u>		10411	(104)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Camden St.</u> St. <u>13</u> Ward)		Registration Dist. No. <u>333</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Nathan G. West</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)			
6 DATE OF BIRTH <u>June 16th</u> , 19 <u>13</u> (Month) (Day) (Year)					
7 AGE <u>1</u> yrs. <u>4</u> mos. <u>9</u> ds. If LESS than 1 day,hrs. ORmin. ?					
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Delmar Del.</u>					
PARENTS	10 NAME OF FATHER <u>Nathan G. West</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Delmar Md.</u>				
	12 MAIDEN NAME OF MOTHER <u>Letitia P. Leathbury</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Nathan G. West</u> (Address) <u>Delmar Del.</u>					
15 FILED <u>Oct 26</u> , 19 <u>14</u> <u>M. B. Burnis</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 25</u> , 19 <u>14</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 19</u> , 19 <u>14</u> , to <u>Oct 25</u> , 19 <u>14</u> , that I last saw him alive on <u>Oct 25</u> , 19 <u>14</u> , and that death occurred on the date stated above, at <u>10 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Ileo Colitis</u>					
(Duration)yrs.mos. <u>10</u> ds.					
Contributory Secondary (Duration)yrs.mos.ds.					
(Signed) <u>M. B. Burnis</u> , M. D. <u>Oct 26</u> , 19 <u>14</u> (Address) <u>Salisbury Md.</u>					
*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of deathyrs.mos.ds. In the Stateyrs.mos.ds. Where was disease contracted, If not at place of death? Former or usual residence					
19 PLACE OF BURIAL OR REMOVAL <u>Delmar Del.</u>				DATE OF BURIAL <u>Oct. 27th</u> , 19 <u>14</u>	
20 UNDERTAKER <u>Geo. C. Hill</u>				ADDRESS <u>Salisbury</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Cmcl.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

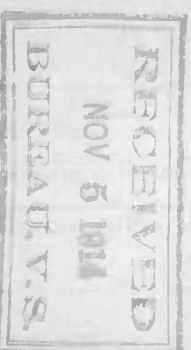
[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Composer*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Fireman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease CAUSING DEATH, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Neomica</u>		10412	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Camden East</u> St.; <u>13</u> Ward)		Registration Dist. No. <u>333</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]
2 FULL NAME <u>Harry Edward White</u>				
PERSONAL AND STATISTICAL PARTICULARS				
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>		
6 DATE OF BIRTH <u>July 24</u> , 1914 (Month) (Day) (Year)				
7 AGE _____ yrs. <u>3</u> mos. <u>3</u> ds. If LESS than 1 day, _____ hrs. OR _____ min. ?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>None</u> (b) General nature of industry, business, or establishment in which employed (or employer)				
9 BIRTHPLACE (State or country) <u>Md</u>				
PARENTS				
10 NAME OF FATHER <u>Harry L White</u>				
11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
12 MAIDEN NAME OF MOTHER <u>Annie Bacon</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Nel</u>				
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Annie White</u> (Address) <u>Salisbury Md</u>				
15 Filed <u>Oct 29</u> , 1914 <u>Banner</u> REGISTRAR				
MEDICAL CERTIFICATE OF DEATH				
16 DATE OF DEATH <u>Oct 27</u> , 1914 (Month) (Day) (Year)				
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 24</u> , 1914, to <u>Oct 27</u> , 1914, that I last saw him alive on <u>Oct 27</u> , 1914, and that death occurred on the date stated above, at <u>3 P.</u> m. The CAUSE OF DEATH* was as follows: <u>Gastro Enteritis</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory <u>Impure food</u> Secondary (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>C. R. Smith</u> , M. D. <u>Oct 27</u> , 1914 (Address) <u>Salisbury Md</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.				
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, if not at place of death? Former or usual residence _____				
19 PLACE OF BURIAL OR REMOVAL <u>Laurel Wel</u>			DATE OF BURIAL <u>Oct 28</u> , 1914	
20 UNDERTAKER <u>Hallomay & Co</u>			ADDRESS <u>Salisbury Md</u>	

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asphyxia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Hæmiplegia," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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1 PLACE OF DEATH County <u>Wicomico</u>		STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Salisbury</u> (No. <u>Camden Dist.</u> St.; <u>13</u> Ward)		Registration Dist. No. <u>333</u>	
2 FULL NAME <u>Ida J. White</u>			
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX <u>Female</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)	
6 DATE OF BIRTH <u>June 15, 1878</u> (Month) (Day) (Year)			
7 AGE <u>36</u> yrs. <u>4</u> mos. <u>9</u> ds.		If LESS than 1 day, ____ hrs. OR ____ min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work <u>Housewife</u> (b) General nature of industry, business, or establishment in which employed (or employer)			
9 BIRTHPLACE (State or country) <u>Md.</u>			
PARENTS	10 NAME OF FATHER <u>George Morris</u>		
	11 BIRTHPLACE OF FATHER (State or country) <u>Md.</u>		
	12 MAIDEN NAME OF MOTHER <u>Maria Trader</u>		
	13 BIRTHPLACE OF MOTHER (State or country) <u>Md.</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>John W. White</u> (Address) <u>McHimmie Park, Va.</u>			
15 Filed <u>Oct. 23, 1914</u> <u>N. P. Turner</u> REGISTRAR			
MEDICAL CERTIFICATE OF DEATH			
16 DATE OF DEATH <u>Oct. 23, 1914</u> (Month) (Day) (Year)			
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct. 23, 1914</u> to <u>Oct. 23, 1914</u> that I last saw her alive on <u>Oct. 23, 1914</u> and that death occurred on the date stated above, at <u>8 p.</u> m.			
The CAUSE OF DEATH* was as follows: <u>Intestinal Obstruction</u> <u>unknown</u> Contributory <u>General Peritonitis</u> Secondary <u>unknown</u>			
(Signed) <u>Oct. 23, 1914</u> <u>Salisbury, Md.</u> *State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.			
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death ____ yrs. ____ mos. <u>1</u> ds. to the State ____ yrs. ____ mos. <u>1</u> ds. Where was disease contracted, <u>Accomac Co. Va.</u> If not at place of death? Former or usual residence <u>Accomac Co. Va.</u>			
19 PLACE OF BURIAL OR REMOVAL <u>Fruitland, Md.</u>		DATE OF BURIAL <u>10/26, 1914</u>	
20 UNDERTAKER <u>Holloway & Co. Salisbury</u>		ADDRESS	

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

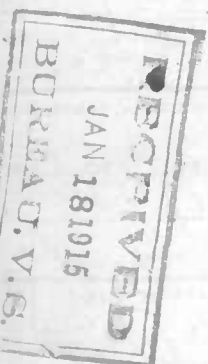
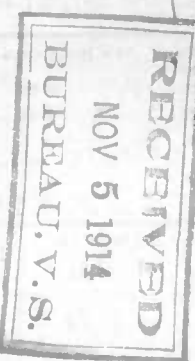
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Statement of cause of death—Name, first, the disease CAUSING DEATH (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

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Sent out
to be
signed
in ink



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1 PLACE OF DEATH

10414

County

Wicomico

P. G. Hospital

STATE OF MARYLAND
CERTIFICATE OF DEATH

Registration Dist. No.

333

Village or City

Salisbury

(No.

Camden Dist

St.

13 Ward

[It death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME

Laura Frances White

PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Female

4 COLOR OR RACE

White

5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)

Married

6 DATE OF BIRTH

Nov.

16th

1946

(Month)

(Day)

(Year)

7 AGE

67

yrs.

10

mos.

15

ds.

If LESS than 1 day, hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work

Housewife

(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

Maryland

PARENTS

10 NAME OF FATHER

George Riall

11 BIRTHPLACE OF FATHER (State or country)

Maryland

12 MAIDEN NAME OF MOTHER

Louisa M. Lecomore

13 BIRTHPLACE OF MOTHER (State or country)

Maryland

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

E. Riall White

(Address)

Salisbury Md.

15

Oct 2, 1914

M. Burner

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

Oct.

1st

1914

(Month)

(Day)

(Year)

17

I HEREBY CERTIFY, That I attended deceased from

April 20, 1914

to

Oct 2, 1914

that I last saw him alive on

Sept 20, 1914

and that death occurred on the date stated above, at 7 A. M.

The CAUSE OF DEATH* was as follows:

Cancer Liver (Duration) 20 yrs. 10 mos. 15 ds.

Contributory Secondary

Gold Star (Duration) 20 yrs. 10 mos. 15 ds.

(Signed) Geo. H. Ford, M. D. Oct 2, 1914 (Address) Salisbury Md

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (For Hospitals, Institutions, Transients, or Recent Residents)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL

DATE OF BURIAL

Persons Cem. Salisbury Md.

Oct. 3rd 3 P.M. 1914

20 UNDERTAKER

ADDRESS

Geo. C. Hill

Salisbury

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

Vond.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

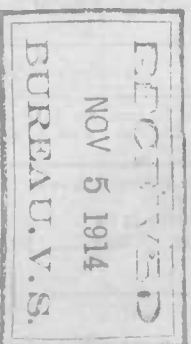
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WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Wicomico</u>		10415	(S)	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>New Salisbury</u> (No. <u>Parsons first</u> St.; <u>5</u> Ward)		Registration Dist. No. <u>333</u>		[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>Infant no name</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)			
6 DATE OF BIRTH <u>Oct 27</u> , 191 <u>4</u> (Month) (Day) (Year)					
7 AGE <u>Still born</u> yrs. mos. ds.		If LESS than 1 day, hrs. OR min. ?			
8 OCCUPATION (a) Trade, profession, or particular kind of work. (b) General nature of industry, business, or establishment in which employed (or employer)					
9 BIRTHPLACE (State or country) <u>Md</u>					
PARENTS	10 NAME OF FATHER <u>J. Isaac Wilkins</u>				
	11 BIRTHPLACE OF FATHER (State or country) <u>Md</u>				
	12 MAIDEN NAME OF MOTHER <u>Lillie Gillis</u>				
13 BIRTHPLACE OF MOTHER (State or country) <u>Del</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>J. Isaac Wilkins</u> (Address) <u>Salisbury, Md. R.D. #3</u>					
15 FILED <u>Oct 27</u> , 191 <u>4</u> , <u>N. Burns</u> REGISTRAR					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>Oct 27</u> , 191 <u>4</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>Oct 27</u> , 191 <u>4</u> , to <u>Oct 27</u> , 191 <u>4</u> , that I last saw h. <u>Still Born</u> alive on <u>Still Born</u> , 191 <u>4</u> , and that death occurred on the date stated above, at _____ m. The CAUSE OF DEATH* was as follows: <u>Still Born</u> (Duration) _____ yrs. _____ mos. _____ ds. Contributory _____ Secondary _____ (Duration) _____ yrs. _____ mos. _____ ds. (Signed) <u>D. B. R. Otto</u> , M. D. <u>Oct 27</u> , 191 <u>4</u> . (Address) <u>Salisbury, Md.</u> *State the DISEASE CAUSING DEATH, or, in death from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds. Where was disease contracted, If not at place of death? Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Wilkins farm Wicomico</u>					DATE OF BURIAL <u>Oct 27</u> , 191 <u>4</u>
20 UNDERTAKER <u>Halloway & Co</u>					ADDRESS <u>Salisbury Md</u>

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

Statement of occupation—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Composer, Architect, Locomotive engineer, Civil engineer, Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uræmia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal *septicæmia*," "Puerperal *peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, suicidal, or homicidal, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

NOV 5 1914

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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10416

1 PLACE OF DEATH

County WicomicoVillage or City Mardela Springs (No. 189)STATE OF MARYLAND
CERTIFICATE OF DEATHRegistration Dist. No. 330

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Lella M. Woollen

PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED Single
(Write the word)

6 DATE OF BIRTH July 23, 1914
(Month) (Day) (Year)

7 AGE 3 yrs. 3 mos. 4 ds. It LESS than 1 day, hrs. OR min. ?

8 OCCUPATION
(a) Trade, profession, or particular kind of work
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE (State or country) Maryland

10 NAME OF FATHER Wm. H. Woollen

11 BIRTHPLACE OF FATHER (State or country) Maryland

12 MAIDEN NAME OF MOTHER Annie P. Bennett

13 BIRTHPLACE OF MOTHER (State or country) Ind

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm. H. Woollen(Address) Mardela15 Filed 191

REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH Oct 27, 1914
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from _____, 191____, to _____, 191____,

that I last saw h. _____ alive on _____, 191____

and that death occurred on the date stated above, at _____ m.

The CAUSE OF DEATH* was as follows:

Unknown

(Duration) _____ yrs. _____ mos. _____ ds.

Contributory
Secondary

(Duration) _____ yrs. _____ mos. _____ ds.

(Signed) J. L. English Reg. M. D.
, 191____ (Address)

*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death _____ yrs. _____ mos. _____ ds. In the State _____ yrs. _____ mos. _____ ds.

Where was disease contracted, If not at place of death?

Former or usual residence _____

19 PLACE OF BURIAL OR REMOVAL Mardela Ind DATE OF BURIAL Oct 28, 1914

20 UNDERTAKER A. L. Seabrook ADDRESS Mardela

REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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